

**WELLINGTON UTILITIES
APPLICATION FOR MEDICAL ALERT CUSTOMER STATUS**

I certify that I have, or someone in my household has, a medical need for water. This condition is certified by a licensed physician practicing in the State of Florida. I understand that it is my responsibility to pay any outstanding utility bills to Wellington Utilities, and that failure to do so will result in termination of utility services. I also understand that water served to my residence is subject to unscheduled interruptions and that it is my responsibility to report them to the Wellington Utilities.

Utilities Account #

Date Signed

Service Address

City

State

Zip

Print/Type Name of Person with
Medical need.

Signature of Person, Parent or Guardian of
Person with Medical need.

PHYSICIAN'S STATEMENT OF CERTIFICATION

Note to Physician: Please complete all spaces provided

This is to certify that _____ has a medical need for water and could suffer life threatening conditions if without water for more than _____ hours. I recommend that water not be intentionally interrupted without prior notification. This certification is effective _____ through _____.
Date Date

Physician's Name

Physician's Address

Physician's Telephone Number

Physician's License or Certification Number

Physician's Signature

Note: This special service is subject to expiration on or after the date provided by the licensed physician.